AMBULANCE SERVICES
APPENDICES

APPENDIX 1a
AMBULANCE - EMERGENCY, ONE ROUND TRIP WITH NONEMERGENCY RETURN DESTINATION

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [A] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Ima A.

3. PATIENT'S BIRTH DATE MM DD YY: SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-D

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring Provider

17a. I.D. NUMBER OF REFERRING PHYSICIAN: A12345

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V919 3. ____.__

2. V920 4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

PHYSICIAN OR SUPPLIER INFORMATION

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY		2	9	A0010		1	XX XX	1		E		
2 MM DD YY		2	9	A0020		1	XX XX	9.5		E		
3 MM DD YY		2	9	A0060		2	XX XX	1				
4 MM DD YY		7	9	W9072		2	XX XX	9.5				
5												
6												spenddown XX.XX

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized

SIGNED MM/DD/YY DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

11223344

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Wilson
Anytown, WI 55555

PIN# 76543218 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 1b
AMBULANCE - EMERGENCY TRIP

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Ima A.	3. PATIENT'S BIRTH DATE MM DD YY; SEX: M [X] F ☐		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 609 Willow St.	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐		7. INSURED'S ADDRESS (No., Street)
CITY: Anytown; STATE: WI	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐		CITY; STATE
ZIP CODE: 55555; TELEPHONE (Include Area Code): (XXX) XXX - XXXX	Employed ☐ Full-Time Student ☐ Part-Time Student ☐		ZIP CODE; TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-D	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO		a. INSURED'S DATE OF BIRTH MM DD YY; SEX: M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX: M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V919 2. ____ 3. ____ 4. ____		22. MEDICAID RESUBMISSION CODE; ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY	1	9	A0010		1	XX XX	1		E		
2 MM DD YY	1	9	A0020		1	XX XX	15		E		
3											
4											
5											
6											spenddown XX XX

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO: 1234JED	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $ XXX XX; 29. AMOUNT PAID $ 0 00; 30. BALANCE DUE $ XXX XX
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Authorized SIGNED MM/DD/YY DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 11223344		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 1 W. Williams Anytown, WI 55555 76543218 PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 1c
AMBULANCE - NONMERGENCY, ONE ROUND TRIP WITH ONE MEDICAL FACILITY DESTINATION

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) A (Medicaid #) ( ) (Sponsor's SSN) ( ) (VA File #) ( ) (SSN or ID) ( ) (SSN) ( ) (ID)			1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M ( ) F (X)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Recipient, Ima A.			
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)
609 Willow St.	Self ( ) Spouse ( ) Child ( ) Other ( )		
CITY / STATE	8. PATIENT STATUS		CITY / STATE
Anytown WI	Single ( ) Married ( ) Other ( )		
ZIP CODE / TELEPHONE (Include Area Code)	Employed ( ) Full-Time Student ( ) Part-Time Student ( )		ZIP CODE / TELEPHONE (INCLUDE AREA CODE)
555555 (XXX)XXX-XXXX			( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
OI-D			
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ( ) NO ( )		a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ( ) F ( )
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ( ) F ( )	b. AUTO ACCIDENT? YES ( ) NO ( ) PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ( ) NO ( )		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO ( ) *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
I.M. Referring Provider	A12345	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V920 2. ____ 3. ____ 4. ____		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY	2	9	A0150		1	XX XX	1				
2 MM DD YY	2	9	W9072		1	XX XX	20				
3 MM DD YY	2	9	A0060		1	XX XX	1				
4 MM DD YY	7	9	W9072		1	XX XX	20				
5											
6											spenddown XX.XX

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ( ) NO ( )	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
( ) ( )	1234JED		$ XXX XX	$ 0.0	$ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Authorized	11223344	I.M. Billing 1 W. Williams Anytown, WI 55555 76543218
SIGNED MM/DD/YY DATE		PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

APPENDIX 1d
SAMPLE EMC SCREEN

MEDVENDR ECS SCREEN
The field numbers on the ECS screen correspond with the numbered data elements on the HCFA 1500 claim form. This screen is to be used beginning 01/04/93.

WELCOME TO ELECTRONIC CLAIMS SUBMISSION DATE 01/04/93
EDS - WISCONSIN MEDICAID

BP NBR 33 L NAME 2 F NAME 2 MID 1a
PCN 26 OI 9 TPL 10 MSC 11 PA NBR 23
RP NBR 17 FP NBR 32 OP NBR
DIAG 1 21.1 2 21.2 3 21.3 4 21.4 5

DTL	FDOS	A1A2A3	POS	PROC	M1	M2	PP NBR	DX	CHARGE	UNIT	TOS	EMG	H/F
1	24.A	A	B	D	D	D	K	E	F	G	C	I	H
2													
3													
4													
5													
6													
7													
8													
9													
0													

TOT BILL 28 OI PAID 29 PAT PAID 24.K NET BILL 30

Doc #1 Page #1 Field #5 Form: MEDVENDR 01-04-1993 14:59:02

BENEFITS OF ELECTRONIC BILLING
One of the greatest benefits of electronic billing is that less information is required for processing. Less information means less room for error. The data element that are not required on electronic claims include:

- claim sort indicator
- patient's date of birth
- patient's address
- patient's sex
- signature of provider
- provider's name and address

Other benefits of billing electronically include:

- free software
- improved cash flow
- lower detail denial rate
- flexible submission methods
- claim entry controlled by provider
- online edits

To request more information on electronic claims submission contact the Electronic Media Claims (EMC) Department at the address located in Section 4 of the handbook, or fill out the Paperless Claims Request form located at the back of this handbook.

APPENDIX 2
NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS FOR AMBULANCE SERVICES

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

☑ = Elements that are required.

☑ **ELEMENT 1 - Program Block/Claim Sort Indicator**
Enter claim sort indicator "A" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

☑ **ELEMENT 1a - INSURED'S I.D. NUMBER**
Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

☑ **ELEMENT 2 - PATIENT'S NAME**
Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

☑ **ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX**
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

☑ **ELEMENT 5 - PATIENT'S ADDRESS**
Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

☑ **ELEMENT 9 - OTHER INSURED'S NAME**
Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third party billing according to Appendix 18a of the WMAP Part A Provider Handbook.

- When the provider has billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, the service does not require third party billing according to Appendix 18a of the WMAP Part A Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires third party billing according to Appendix 18a of the WMAP Part A Provider Handbook, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by other insurance following submission of a correct and complete claim or payment was applied towards the coinsurance and deductible. DO NOT use this code unless the claim in question was actually billed to and denied by the private insurer.
OI-Y	YES, the card indicates other coverage but it was not billed for reasons including, but not limited to: - recipient denies coverage or will not cooperate; - the provider knows the service in question is noncovered by the carrier; - insurance failed to respond to initial and follow-up claim; or - benefits not assignable or cannot get an assignment.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

☑ **ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER**
This first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing to the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes and home health agencies when Medicare had made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.
M-6	Recipient not Medicare eligible.
M-7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
M-8	Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medical Assistance identification card indicates no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefit (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of the WMAP Part A Provider Handbook for further information regarding the submission of claims for dual entitlees.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE
(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

☑ **ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE**
Required for non-emergency services. Enter the referring or prescribing physician's name.

☑ **ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN**
When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the WMAP provider number or license number of the referring provider. To obtain a UPIN directory, refer Appendix 3 of the WMAP Part A Handbook.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE (not required)

ELEMENT 20 - OUTSIDE LAB (not required)

☑ **ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**
Diagnosis codes for ambulance: V919 - Emergency
V920 - Non-Emergency Prescription on File.
The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

☑ **ELEMENT 23 - PRIOR AUTHORIZATION**
Enter the seven-digit prior authorization number from the approved prior authorization request form. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

☑ **ELEMENT 24A - DATE(S) OF SERVICE**
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD)

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge per detail line in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same emergency indicator.

☑ **ELEMENT 24B - PLACE OF SERVICE**
Enter the appropriate WMAP single-digit place of service code for each service. Refer to Appendix 4 of this handbook for a list of allowable place of service codes.

☑ **ELEMENT 24C - TYPE OF SERVICE CODE**
Enter the single-digit type of service code "9".

☑ **ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES**
Enter the appropriate five-character procedure code. Refer to Appendix 3 of this handbook for a list of allowable procedure codes.

☑ **ELEMENT 24E - DIAGNOSIS CODE**
When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

☑ **ELEMENT 24F - CHARGES**
Enter the total charge for each line.

☑ **ELEMENT 24G - DAYS OR UNITS**
Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed.

ELEMENT 24H - EPSDT/FAMILY PLANNING (not required)

☑ **ELEMENT 24I - EMG**
Enter an "E" for each procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency leave element blank.

ELEMENT 24J - COB (not required)

☑ **ELEMENT 24K - RESERVED FOR LOCAL USE**
When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of the WMAP Part A Provider Handbook for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

☑ **ELEMENT 26 - PATIENT'S ACCOUNT NO.**
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT
(Not required, provider automatically accepts assignment through Medical Assistance certification.)

☑ **ELEMENT 28 - TOTAL CHARGE**
Enter the total charges for this claim.

☑ **ELEMENT 29 - AMOUNT PAID**
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

☑ **ELEMENT 30 - BALANCE DUE**
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER
The provider of the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medical Assistance provider number.

ELEMENT 33 - PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

APPENDIX 3
HCPCS PROCEDURE CODE AND COPAYMENT TABLE FOR AMBULANCE SERVICES

The HCFA Common Procedure Code System (HCPCS) is required for all transportation claims. Please refer to the following table to determine the usage of the appropriate code.

Procedure Code	Description	TOS	POS	Copayment
Ambulance				
A0010	Emergency Base Rate	9	1,2	n/a
A0020	Emergency Mileage	9	1,2	n/a
A0150	Non-Emergency Base Rate	9	1,2,3,4,7.8.9,B	2.00[1]
W9072	Non-Emergency Mileage	9	1,2,3,4,7,8,9,B	n/a
W9081	Multiple Carry Base Rate	9	1,2,3,4,7,8	n/a
W9082	Multiple Carry Mileage, Two Recipients	9	1,2,3,4,7,8	n/a
W9083	Multiple Carry Mileage, Three or More Recipients	9	1,2,3,4,7,8	n/a
Miscellaneous Services				
A0060	Waiting Time	9	2,3,7,8,B	n/a
W9078	Third Attendant	9	0,1,2,3,4,7,8,B	n/a
W9051	Ambulance First Aid at the Scene	9	0,3,4,7,8	n/a
A0070	Oxygen	9	0,1,2,3,4,7,8,9,B	n/a
A0215	Disposable Items	9	0,1,2,3,4,7,8,9,B	n/a
W9074	Isolette, up to three hours	9	1,2	n/a
W9075	Isolette, over three hours	9	1,2	n/a
Air Ambulance				
W9060	Emergency Base Rate	9	0,1,2,9	n/a
W9061	Emergency Mileage	9	0,1,2,9	n/a
W9062	Non-Emergency Base Rate	9	0,1,2,4,9	n/a
W9063	Non-Emergency Mileage	9	0,1,2,4,9	n/a
Water Ambulance				
A0050	Emergency Rate	9	0,1,2,9	n/a
W9050	Non-Emergency Rate	9	0,1,2,9	n/a

[1] Places of service 7 and 8 are exempt from recipient copayment. Refer to Section I-C of this handbook for additional copayment exemptions.

APPENDIX 4

WMAP ALLOWABLE PLACE OF SERVICE (POS) CODES

POS	Description
0	Other
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility
9	Ambulance
B	Ambulatory Surgical Center

WMAP ALLOWABLE TYPE OF SERVICE CODE

POS	Description
9	Other

APPENDIX 5
PRIOR AUTHORIZATION REQUEST FORM (PA/RF) SAMPLE
NONEMERGENCY TRANSPORTATION

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE
999

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER
1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
Recipient Ima A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
609 Willow
Anytown, WI 55555

5 DATE OF BIRTH
MM/DD/YY

6 SEX M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER
(XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
Ambulance Provider
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.
12345678

10 DX: PRIMARY
V920

11 DX: SECONDARY

12 START DATE OF SOI:

13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
A0150		8	9	Non-emergency Base Rate	1	XX.XX
W9072		8	9	Non-emergency Mileage	40	XX.XX
					TOTAL CHARGE	21 XXX.XX

22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)

24 J. M. Provider (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

APPENDIX 6
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)
COMPLETION INSTRUCTIONS

ELEMENT 1 - PROCESSING TYPE
Enter processing type "999".

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the ten-digit Medical Assistance recipient identification number as found on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX
Enter an "X" to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS, AND ZIP CODE
Enter the name and complete address (street, city, state, and zip code) of the billing provider. No other information should be entered in this element since it also serves as a return mailing label.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter diagnosis code V920 - Non-Emergency Service, Prescription on File.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS (not required)

ELEMENT 12 - START DATE OF SPELL OF ILLNESS (not required)

ELEMENT 13 - FIRST DATE OF TREATMENT (not required)

ELEMENT 14 - PROCEDURE CODE(S)
Enter the appropriate HCPCS procedure code for each service requested in this element.

ELEMENT 15 - MODIFIER (not required)

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate single-digit place of service code designating the destination of the transport. Refer to Appendix 4 of this handbook for a list of allowable place of service codes.

ELEMENT 17 - TYPE OF SERVICE
Enter type of service code "9".

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate HCPCS procedure code for each service requested.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the quantity (e.g., number of services or number of miles) requested for each service requested.

ELEMENT 20 - CHARGES
Enter your usual and customary charge for each service requested. If the quantity is greater than "1", multiply the quantity by the charge for each service requested. Enter that total amount in this element.

NOTE: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health and Social Services.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
"An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO."

ELEMENT 23 - DATE
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider requesting/performing/procedure must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER - - THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

APPENDIX 7
PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT (PA/PA) SAMPLE

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/PA

PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Ima	A	1234567890	84

PROVIDER INFORMATION

(6) PERFORMING PROVIDER'S NAME	(7) PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) PERFORMING PROVIDER'S TELEPHONE NUMBER
I. M. Provider	65432187	(XXX) XXX-XXXX

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME: I. M. Physician, M.D.

A. Describe diagnosis and clinical condition pertinent to service or procedure requested:

Patient is an 84-year old male who suffers from fractured hip and severe arthritis. Is medically stable but unable to walk or sit upright for long periods of time. Patient requires ambulance transportation to geriatric facility in prone or semi-reclining posture.

B. Describe medical history pertinent to service or procedure requested:

Patient was released from geriatric facility for a family gathering in Upper Peninsula. At the gathering, patient fell and broke his hip. Patient was stabilized and treated at local hospital but the fracture aggravated pre-existing rheumatic discomfort. Patient requires care at the geriatric facility. Patient is receiving 10mg codeine enhanced pain reliever PRN.

C. Supply justification for service or procedure requested:

See Sections A and B for background. Patient cannot tolerate transportation in a sitting position. Cot stretcher required, but no medical treatment will be needed during the trip.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

D. 2/3/93 (Date) L. M. Provider (Requesting Provider's Signature)

APPENDIX 8
PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT (PA/PA)
COMPLETION INSTRUCTIONS

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the Prior Authorization Request Form (PA/RF) or the Prior Authorization Physician Attachment (PA/PA) may be addressed to EDS' Telephone/Written Correspondence Unit.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Enter the age of the recipient in numerical form (e.g., 45, 60, 21).

PROVIDER INFORMATION:

ELEMENT 6 - PRESCRIBING PHYSICIAN'S NAME
Enter the name of the provider who would perform/provide the requested service/procedure.

ELEMENT 7 - PRESCRIBING PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the physician prescribing the service.

ELEMENT 8 - PRESCRIBING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the provider prescribing the service.

ELEMENT 9 - REFERRING/PRESCRIBING PHYSICIAN'S NAME
Enter the name of the referring/prescribing physician in this element.

* *

The remaining portions of this attachment are to be used to document the justification for the requested service/procedure.

1. Complete elements A through D.

2. Read the Prior Authorization Statement before dating and signing the attachment.

3. Date and sign the attachment.

APPENDIX 9
PAPERLESS CLAIMS REQUEST FORM

Please complete this form if you want additional information on electronic billing.

Name: _____

Address: _____

_____

_____

Medicaid Number: _____ **Phone #:** _____

Contact Person: _____

Type of Service(s) Provided: _____

Estimated Monthly Medicaid Claims Filed: _____

* *

1. Do you currently submit your Medicaid claims on paper? __YES __NO

2. Are your Medicaid claims computer generated on paper? __YES __NO

3. Do you use a billing service? __YES __NO
   If the answer is YES to #2 or #3, please complete the following:
   Name: _____ Contact: _____
   Address: _____ Phone #: _____
   _____

4. Do you have an in-house computer system? __YES __NO
   If YES, type of computer system:
   a. Large main frame — Manufacturer: _____
      (e.g., IBM 360, Burroughs 3800) — Model #: _____
   b. Mini-Computer — Manufacturer: _____
      (e.g., IBM System 34, or 36 TI 990) — Model #: _____
   c. Micro-Computer — Manufacturer: _____
      (e.g., IBM PC, COMPAQ, TRS 1000) — Model #: _____

5. Please send the paperless claims manual for:

   __ magnetic tape submission

   __ telephone transmission (EDS free software) ___ 3-1/2" ___ 5-1/4"

   __ telephone transmission (3780 protocol transmission)

Return To: EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009